from a facility unless the facility requests a delay or good cause for the delay is demonstrated to the satisfaction of the hearing officer;

(2) the commissioner must, within 30 days after receiving the recommendation of the hearing officer, either render a decision in the case or refer the case back to a hearing officer for additional findings;

(3) if either time limit set under (1) or (2) of this subsection is not met, the department shall report the noncompliance to the legislature and the governor by the following January 20 with an explanation of the length of delay, reasons for the delay, and proposed corrective action by the department to ameliorate the causes of delay. (§ 4 ch 95 SLA 1983; am E.O. No. 72 § 8 (1989); am §§ 3, 4 ch 153 SLA 1990)

Effect of amendments. — The 1989 amendment, effective March 1, 1989, substituted "department regarding health facility payment rates under this chapter" for "commission under AS 47.07."

The 1990 amendment added the exception at the end of present subsection (a) and added subsection (b).

Sec. 47.07.080. [Renumbered as AS 47.07.900.]

Sec. 47.07.110. Medicaid Rate Advisory Commission established. The Medicaid Rate Advisory Commission is established in the department. (§ 6 ch 95 SLA 1983; am E.O. No. 72 § 9 (1989))

Effect of amendments. — The 1989 amendment, effective March 1, 1989, inserted "Advisory."

NOTES TO DECISIONS

Quoted in City of Cordova v. Medicaid Rate Comm'n, 789 P.2d 346 (Alaska 1990).

Sec. 47.07.120. Composition of commission. The commission consists of five members as follows:

(1) the chief executive officer of a health facility that is licensed by the state but not owned or operated by the state or federal government and that is subject to the budget review process under this chapter;

(2) the commissioner of administration, the commissioner of health and social services, or the appointed designee of either commissioner;

(3) a physician licensed to practice medicine in the state who is actively engaged in the practice of medicine and who is not employed by the state;

(4) a certified public accountant with relevant experience;

(5) a person representing consumers of health services who does not have a direct or indirect interest in an entity that provides health care services. (§ 6 ch 95 SLA 1983)

NOTES TO DECISIONS

Appointment required for participation. — Participation at a commission hearing by a person designated by a commissioner to be a member of the commission was unlawful where such person had not been appointed by the governor. City of Cordova v. Medicaid Rate Comm'n, 789 P.2d 346 (Alaska 1990).

Sec. 47.07.130. Appointment of members. Members of the commission are appointed by the governor and serve at the pleasure of the governor. (§ 6 ch 95 SLA 1983)

NOTES TO DECISIONS

Appointment required for participation. — Participation at a commission hearing by a person designated by a commissioner to be a member of the commission was unlawful where such person had not been appointed by the governor. City of Cordova v. Medicaid Rate Comm'n, 789 P.2d 346 (Alaska 1990).

Sec. 47.07.140. Term of membership. The term of a member of the commission appointed under AS 47.07.120(1), (3), (4), or (5) is three years. A member may not be appointed to a successive term. The terms of the members shall be staggered. A member appointed to fill a vacancy serves for the unexpired term of the member. A term shall be measured from January 1 of the year in which the term of the vacant position begins, regardless of when the vacancy is filled. (§ 6 ch 95 SLA 1983)

Sec. 47.07.150. Compensation. A member of the commission serves without compensation but is entitled to per diem and travel expenses authorized by law for boards and commissions under AS 39.20.180. (§ 6 ch 95 SLA 1983)

Sec. 47.07.160. Officers. At the first meeting of each year, the commission shall elect a chair from among its members. (§ 6 ch 95 SLA 1983)

Sec. 47.07.170. Meetings and quorum. The commission shall meet as often as necessary to conduct its business. Three members of the commission constitute a quorum. (§ 6 ch 95 SLA 1983)

Sec. 47.07.180. Duties. (a) The commission shall advise the department on policies relating to payment rates for health facilities under this chapter and AS 47.25.120 — 47.25.300. The commission may also review the department's regulations on payment rates and recommend an alternative rate-setting system if it determines that the department's system is inadequate.

(b) The commission shall advise the department on the state plan as it relates to health facilities.

(c) *[Repealed, § 6 ch 153 SLA 1990.]*

(d) By March 1 of each year, the department shall develop for the fiscal year starting the next July 1 an annual estimate of medical assistance program expenditures in health facilities under the jurisdiction of the department under this chapter and AS 47.25.120 — 47.25.300. The estimate shall consider anticipated utilization and payment rates for each facility. The methodology used by the department to develop the estimate shall be consistent with the regulations governing the department's rate-setting process. (§ 6 ch 95 SLA 1983; am § 8 ch 105 SLA 1986; am E.O. No. 72 § 10 (1989); am §§ 5, 6 ch 153 SLA 1990)

Effect of amendments. — The 1986 amendment rewrote this section.

The 1989 amendment, effective March 1, 1989, substituted "department" or "department's" for "commission" or "commission's" throughout the section; in subsection (a), deleted "and may review budgets" following "rates" and substituted "advise the department on" for "establish"; in subsection (b), substituted "advise" for "consult with" and deleted a second sentence which prohibited the commission from changing the unit of payment without written consent of the department; in subsection (c), inserted "recommend that the department" and made a stylistic change in the first sentence; and, in subsection (d), substituted "department under this chapter and AS 47.25.120 — 47.25.300" for "commission" at the end of the first sentence.

The 1990 amendment rewrote the first sentence and added the second sentence in subsection (a) and repealed subsection (c), which authorized recommendations that the department redetermine prospective payment rates under certain conditions.

Sec. 47.07.190. Employment of personnel. The department may employ and determine the salary of an executive director, who shall provide staff assistance to the commission. With the approval of the department, the executive director may select and employ additional staff. The commission shall be assisted by the officers or personnel of the department as the commissioner of health and social services directs. The executive director of the commission is in the exempt service under AS 39.25. (§ 6 ch 95 SLA 1983; am E.O. No. 72 § 11 (1989))

Effect of amendments. — The 1989 amendment, effective March 1, 1989, substituted "department" for "commission" in the first and second sentences; added "who shall provide staff assistance to the commission" at the end of the first sentence; and substituted "directs" for "shall direct" at the end of the third sentence.

Sec. 47.07.900. Definitions. In this chapter

(1) "adult dental services" means minimum treatment for the immediate relief of pain and acute infection provided by a licensed dentist;

(2) "chiropractic services" includes only services that are provided by a chiropractor licensed under AS 08.20 that consist of treatment by means of manual manipulation of the spine and x-rays necessary for treatment;

(3) "clinic services" means services provided by state-approved outpatient community mental health clinics that receive grants under AS 47.30.520 — 47.30.620, state-operated community mental health clinics, outpatient surgical care centers, and physician clinics;

(4) "commission" means the Medicaid Rate Advisory Commission;

(5) "department" means the Department of Health and Social Services;

(6) "emergency hospital services" means services that

(A) are necessary to prevent the death or serious impairment of the health of the individual; and

(B) because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available that is equipped to furnish the services, even if the hospital does not currently meet

(i) the conditions for participation under Medicare; or

(ii) the definitions of inpatient or outpatient hospital services under 42 C.F.R. 440.10 and 440.20;

(7) "eyeglasses" are lenses, including frames when necessary, and other aids to vision prescribed by a physician skilled in diseases of the eye, or by an optometrist, whichever the patient may select, to aid or improve vision;

(8) "health facility" includes a hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, and outpatient surgical clinic;

(9) "nurse midwife" means a registered professional nurse who is certified as an advanced nurse practitioner under AS 08.68.410(1) and authorized to practice as a nurse midwife under regulations adopted in accordance with AS 08.68.410(8);

(10) "personal care services in a recipient's home" means services prescribed by a physician in accordance with the recipient's plan of treatment and provided by an individual who is

(A) qualified to provide the services;

(B) supervised by a registered nurse; and

(C) not a member of the recipient's family. (§ 1 ch 182 SLA 1972; am § 2 ch 12 SLA 1976; am § 3 ch 221 SLA 1976; am § 26 ch 40 SLA 1981; am § 4 ch 132 SLA 1982; am §§ 5, 10 ch 95 SLA 1983; am § 3 ch 20 SLA 1986; am §§ 9, 10 ch 105 SLA 1986; am E.O. No. 72 § 12 (1989))

Revisor's notes. — Formerly AS 47.07.080. Renumbered in 1983. Reorganized in 1983 and 1986 to alphabetize the terms defined.

Effect of amendments. — The 1986 amendment inserted "outpatient surgical care centers," in paragraph (3) and added paragraphs (1), (2), (6), and (10). The 1986 amendment of this section by ch. 20 was incorporated in ch. 105.

The 1989 amendment, effective March 1, 1989, inserted "Advisory" in paragraph (4).

ALASKA ADMINISTRATIVE CODE

Title 7

Health and Social Services

JULY 1995 SUPPLEMENT
INCLUDING REGISTERS 127 THROUGH 134

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kia, keratoconus, corneal degeneration, or rejection of an implant, or when other medical reasons exist.

(c) Prior authorization by the division is required for tinted lenses and contact lenses. (Eff. 8/18/79, Register 71; am 9/1/94, Register 131)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.647. CONTRACTED FRAMES AND LENSES. The division will, in its discretion, designate one or more enrolled providers for the purchase of frames or lenses through a contract for services under AS 36.30 (State Procurement Code). (Eff. 9/1/94, Register 131)

Authority: AS 47.05.010 AS 47.07.030

7 AAC 43.650. GLASSES. Repealed. (Eff. 8/18/79, Register 71; repealed 9/1/94, Register 131)

7 AAC 43.655. INDIVIDUAL CONSIDERATION. Repealed. (Eff. 8/18/79, Register 71; repealed 9/1/94, Register 131)

7 AAC 43.656. CONTRACTED FRAMES AND LENSES. Deleted. (Eff. 7/3/94, Register 130; deleted as of Register 131)

Editor's note: As of Register 131, October 1994, and under authority of AS 44.62.125(b)(6), the regulations attorney deleted 7 AAC 43.656 because the substance of that section appears in 7 AAC 43.647.

ARTICLE 12. PROSPECTIVE PAYMENT SYSTEM.

Editor's note: 7 AAC 43.675 — 7 AAC 43.705 were repealed by the Department of Health and Social Services in an emergency action effective 6/27/84, Register 91. The Medicaid Rate Commission adopted 7 AAC 43.670 — 7 AAC 43.709 as emergency regulations, effective 6/27/84, Register 91, to replace the repealed regulations. When the Medicaid Rate Commission emergency regulations were made permanent and amended, effective 10/21/84, Register 92, the substance of the regulations was reorganized and renumbered. The numbering and organization of the material in 7 AAC 43.670 — 7 AAC 43.709, as of 10/21/84, bears no resemblance to the numbering and organization of that material before 10/21/84. Therefore, the history notes for 7 AAC 43.670 — 7 AAC 43.709 do not reflect the history of those sections before 10/21/84, and references to the emergency repeal of the DHSS regulations on 6/27/84 have been deleted.

7 AAC 43.683. INFLATION FACTORS. (a) Before May 1 of each year the department will adopt inflation factors to be used in establishing prospective payment rates for facilities. The department will adopt separate inflation factors for

(1) acute care hospitals and specialty hospitals;

(2) long-term care facilities and intermediate care facilities for the mentally retarded; and

(3) rural health clinics.

(b) The department will consider the following criteria in determining the inflation factors under (a) of this section:

(1) national and regional inflation trends specific to health care;

(2) economic conditions within the state, including inflation trends specific to the state; these trends may be shown through information and data used in forecasts prepared by experts in the field or through other reliable historical information;

(3) regional differences within the state;

(4) budget inflationary factors in medical assistance appropriations set by the legislature; and

(5) other factors the department determines appropriate.

(c) The inflation factors will separately identify annual rates of inflation used to develop the inflation factor and will be consistently applied year to year. (Eff. 8/9/86, Register 99; am 7/4/87, Register 102; am 8/6/92, Register 123; am 12/31/94, Register 132)

Authority: AS 47.07.070 AS 47.07.180

7 AAC 43.685. METHODOLOGY AND CRITERIA FOR APPROVAL OR MODIFICATION OF A FAIR RATE OF PAYMENT FOR MEDICAL ASSISTANCE PROGRAMS. (a) The following methodology and criteria will be used by the department in reviewing and setting prospective payment rates for medical assistance programs; the relative importance of each criterion is a matter of department discretion:

(1) whether the costs are reasonable given prudent and cost-effective management and operation of the facility;

(2) whether the costs are related to patient care and are attributable to the Medicaid and General Relief Medical assistance programs;

(3) whether the prospective rate is reasonably related to costs;

(4) whether the prospective rates are the most reasonable under the circumstances, considering the

(A) rate of use by medical assistance beneficiaries in acute care;

(B) rate of use by medical assistance beneficiaries in long-term care;

(C) overall acute care occupancy; and

(D) overall long-term care occupancy.

(b) For facilities and services of facilities whose respective methodologies for determining a fair rate of payment are not described in this section, the department will determine a fair rate of payment based on actual costs per occasion of service as allowed in 7 AAC 43.686 for the facility's fiscal year ending 12 months before the prospective fiscal year. The actual allowable operating costs will be calculated and adjusted as follows:

(1) The actual allowable operating costs per occasion of service will be calculated from the Medicare cost report for the applicable fiscal year with adjustments as prescribed in the manual if the Medicare cost report does not allocate costs in the required manner.

(2) Actual operating costs less capital costs, which are interest on long-term debt, depreciation, amortization, leases and rentals for real property, exclusive of equipment, property taxes on real property used for direct patient care, and insurance on fixed assets, will be adjusted forward based on a compound rate of inflation as outlined in 7 AAC 43.683. For long-term care facilities and intermediate care facilities for the mentally retarded, the ancillaries will be separately identified from the daily facility expenses.

(3) Interest on long-term debt, depreciation, amortization, leases and rentals for real property, exclusive of equipment, and property taxes on real property used for direct patient care, will be considered based on budget data submitted by the facility as follows:

(A) For facilities that contain both long-term care services and acute care services, budgeted depreciation, interest, and amortization will be allocated using the same methodology as was allowable in the base year.

(B) Additional building depreciation and interest due to the construction of additional beds will be adjusted to reflect 50 percent of the base year occupancy.

(C) An appropriate allowance for depreciation, interest on capital indebtedness and capital for an asset of a hospital that has undergone a change of ownership will be valued at the lesser of the allowance acquisition cost of the asset to the owner of record on or after July 18, 1984, or the acquisition cost of the asset to the new owner in accordance with 42 U.S.C. 1395x(v)(1)(O)(i); in addition, the recapture of depreciation expense on disposition of assets that accommodate gains under the Medicaid program will be limited by the provisions of 42 U.S.C. 1395x(v)(1)(O)(ii); payment for acquisition costs associated with buying and selling of the facility will be limited by the provisions of 42 U.S.C. 1395x(v)(1)(O)(iii); for long-term care facilities, capital assets used by the prior owner in the medical valuation of general relief medical programs for purposes of determining payment rates will

not be increased, as measured from the date of acquisition by the seller to the date of the change of ownership, solely as a result of a change of ownership, by more than the lesser of

(i) one-half of the percentage increase, as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the secretary of the U.S. Department of Health and Human Services in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year or,

(ii) one-half of the percentage increase, as measured over the same period of time, in the Consumer Price Index for All Urban Consumers (United States city average).

(D) For facilities that contain long-term care services, acute care services, or both, the department will determine as a capital cost

(i) the reasonable cost for arms-length transactions for leases and rentals for real property, exclusive of equipment, used for direct patient care, and

(ii) the actual cost for property taxes on real property used for direct patient care.

(4) The department will require the following revenue offsets for determining a fair rate for Medicaid and General Relief Medical assistance programs:

(A) other operating revenue as defined in 7 AAC 43.686(c);

(B) tax revenue designated by the taxing authority for payment of interest expense on bonds and operating costs;

(C) donations or grants that are donor-restricted for operating costs as allowed in 7 AAC 43.686.

(c) If a new facility is licensed, the rates for the first two years of operating will be calculated as follows:

(1) for acute care, the percentage of charges will be set at the statewide weighted average of percentage of charges for the most recent 12 months of actual data available in the commission office;

(2) for long-term care, the rate will be set at the swing bed rate currently in effect, less the average capital costs contained in the swing bed rate, plus the inflation factor adopted under 7 AAC 43.683, plus the capital costs identified by the new facility, assuming a first year occupancy rate of 40 percent and a second year occupancy rate of 60 percent on licensed beds.

(d) The department will determine the percentage of charges for acute care hospitals and specialty hospitals by calculating the ratio of allowable operating costs less the required revenue offset per adjusted admission in the base year, to actual revenue, not to exceed 100 percent of projected charges. The allowable increase or decrease will be calculated in accordance with (b) of this section.

(e) The department will determine a per diem rate for long-term care and intermediate care for the mentally retarded by totalling the allowable operating costs for the daily rate and the average ancillary cost per day, less the required revenue offsets. For a facility that's fiscal year begins on or after January 1, 1995, the department will determine a per diem rate for long-term care and intermediate care for the mentally retarded by totalling the allowable operating costs for the daily rate and the average ancillary lower of costs or charges per day, less the required revenue offsets. The per diem rate may not exceed charges rendered to the general public. For purposes of this subsection, allowable operating costs are as determined in 7 AAC 43.686.

(f) In using the criteria in (a) of this section, the department will compare the allowable costs less capital costs calculated in (b) of this section plus the appropriate annual inflation identified in 7 AAC 43.683 (base year allowable costs) to the approved allowable operating costs less capital per occasion of service in the year preceding the budget year (approved allowable costs) and will apply the following:

(1) if the base year allowable costs exceed the approved allowable costs, the allowable costs will be limited to the approved allowable costs plus the appropriate inflation factor identified in 7 AAC 43.683 plus 50 percent of the difference between the allowable costs of the two years, limited to 5 percent of the costs in the base year;

(2) if the allowable costs are less than the approved allowable costs, rates will be calculated in accordance with (b) of this section plus 50 percent of the difference between the allowable costs of the two years, limited to 5 percent of the costs in the base year;

(3) for long-term care facilities, allowable costs do not include ancillary costs.

(g) For long-term care services provided on or after November 1, 1988, the department will limit the routine portion of the rate for a long-term care facility to one that is the lesser of either the rates for the long-term care facility as calculated in (a) — (f) of this section or the maximum cap, calculated under (1) — (3) of this subsection. The department will, under (1) — (3) of this subsection, recalculate the maximum cap every six months and will reset prospective rates for all long-term care facilities for the subsequent six-month period by applying the new maximum cap established for that period. The maximum cap is calculated as follows:

(1) The department will place all long-term care facilities whose rates are set under AS 47.07.070 into three categories, consisting of free-standing facilities, facilities co-located with hospitals, and state-owned facilities.

(2) The department will calculate a separate maximum cap for the long-term care facilities listed in each of the three categories listed in (1) of this subsection. The department will calculate the

maximum cap for each category semi-annually, for the periods of January 1 — June 30 and July 1 — December 31.

(3) The maximum cap is the weighted average of the rates for routine services established by the department for the preceding 12 months for the category of long-term care facility, as adjusted by the inflation factor adopted by the department under 7 AAC 43.683.

(h) The department will express acute care hospital and specialty hospital rates as a percentage of charges and average rate per adjusted admission with anticipated medical assistance admissions and medical assistance adjusted admissions.

(i) The department will express long-term care facility and intermediate care facility for the mentally retarded rates as a per diem rate with anticipated medical assistance patient days and dollar amount per day that represents medical assistance patient-specific ancillaries.

(j) The department will determine a fair rate of payment for rural health clinics based on actual allowable costs for each occasion of service as determined by the Medicare carrier under 42 C.F.R. 405.2426 — 2429 for the rural health clinic's fiscal year ending 12 months before the prospective fiscal year. The actual allowable costs will be adjusted as follows:

(1) Actual operating costs will be adjusted forward based on a compound rate of inflation as outlined in 7 AAC 43.683. The ancillaries will be separately identified from the clinic visit rate.

(2) The department will require revenue offsets, described in (b)(4) of this section, for determining a fair rate of payment for rural health clinics.

(3) The prospective payment rate will not exceed the payment limit set by the Health Care Financing Administration, U.S. Department of Health and Human Services, which is in effect 60 days before the rural health clinic's fiscal year begins.

(k) The department will express rural health clinic rates as a per-visit rate, with anticipated medical assistance visits and dollar amount for each visit, that represents medical assistance patient-specific ancillaries.

(*l*) The department will determine a fair rate of payment for outpatient surgical centers based on reasonable costs as determined under 42 C.F.R. 416.100 — 140.

(m) The department will determine a fair rate of payment for a hospital outpatient laboratory service based on reasonable costs as determined by the Medicare fee schedule.

(n) The department will express an outpatient surgical center rate as a four part per-procedure rate with anticipated Medical Assistance procedures.

(*o*) For assessments, reviews, and plans of care, the rate of a long-term care facility calculated under (a) — (g) of this section is adjusted upward by an increment that is the sum of the facility's medical assis-

tance admissions during the base year multiplied by 3.91, plus the average number of medical assistance patients in the facility during the base year multiplied by 2.73, then multiplied by the product of 1.281 multiplied by the sum of the average registered nurse wage rate in the appropriate region plus half of the difference between that average registered nurse wage rate and the highest reported registered nurse wage rate in that appropriate region; the resulting product is then divided by the number of medical assistance patient days in the facility during the base year. If the base year allowable costs rather than the approved year rate are used in setting the facility's prospective rate and all or a portion of a facility's base year used in setting that rate includes any time after October 1, 1990, the rate increment under this subsection is reduced by the percentage of the base year, by month, that includes any time after October 1, 1990. This subsection takes effect October 1, 1990.

(p) For a computerized patient assessment system, the rate of a long-term care facility calculated under (a) — (g) of this section is adjusted upward by an increment that is the result of dividing $6,700 by the number of medical assistance patient days in the facility's base year. If the facility does not have a January through December fiscal year, the number of medical assistance patient days in the facility's base year used in the calculation under this subsection is the product of total base year medical assistance patient days divided by 12 months, multiplied by the number of months remaining in the fiscal year to accomplish payment of the $6,700 by the end of the fiscal year in progress on January 1, 1991. The adjustment applies only to the fiscal year in progress on January 1, 1991. This subsection takes effect January 1, 1991.

(q) For patient assessment system training, the rate calculated under (a) — (g) of this section of a long-term care facility not located in Anchorage is adjusted upward by an increment that is the result of dividing the sum of $285 and the August, 1990 round trip airfare between Anchorage and the location of the respective long-term care facility, as set out in this subsection, by the number of medical assistance patient days in the facility's base year. If the facility does not have a January through December fiscal year, the number of medical assistance patient days in the facility's base year used in the calculation under this subsection is the product of total base year medical assistance patient days divided by 12 months multiplied by the number of months remaining in the fiscal year to accomplish payment of amounts described in this subsection by the end of the fiscal year in progress on January 1, 1991. The adjustment applies only to the fiscal year in progress on January 1, 1991. The round trip airfares used in the calculation under this subsection are as follows:

Cordova	$180
Fairbanks	$278